CE: (TEMOTOT	WEDIENIE & MEDIE	- SERVICES			ONIB 110. 0200 0031
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		00	COMPLETED
		155580	A. BUILDING		05/17/2011
		100000	B. WING		00/11/2011
NAME OF B	ROVIDER OR SUPPLIE	D	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	KOVIDEK OK SUPPLIEI	K.	2350 TA	AFT STREET	
TIMBER\	/IEW HEALTH CAF	RE CENTER	GARY	IN46404	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0000					
1 0000					
	This wisit was fo	or the Investigation of	F0000		ł
		or the Investigation of	F0000		
	Complaints IN0	0090131 and			
	IN00090300.				
	C1-1-1-1-1	INIOOOO121			
	Complaint numb				
	substantiated no	deficiencies related to the			
	allegations are c	ited			
	unio guino no unio u				
	Complaint numb	per IN00090300			
	substantiated, Fe	ederal/State deficiencies			
		egations are cited at F 223			
		_			
	F 225, F 226, F	279, and F 323.			
	Survey dates: M	May 16 and 17, 2011			
	Burvey dutes. 17	1ay 10 and 17, 2011			
	Facility number:	: 008505			
	Provider number	r: 155580			
	AIM number: 2				
	Alivi liullibet. 2	.00004830			
	Survey team: J	anelyn Kulik, RN			
	•	•			
	Comana 11 4				
	Census bed type	<del>.</del>			
	SNF/NF: 128				
	Total: 128				
	Census payor ty	pe:			
	Medicare: 22				
	Medicaid: 95				
	Other: 11				
	Total: 128				
	Comple: 10				
	Sample: 10				1

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:  155580		(X2) MULTIPLE CONSTRUCTION  A. BUILDING B. WING  (X3) DATE SUR  COMPLETE  05/17/2011			ETED		
	PROVIDER OR SUPPLIER		B. WIIV	STREET A	DDRESS, CITY, STATE, ZIP CODE SFT STREET N46404		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F0223 SS=D	findings cited in 16.2.  Quality review or Cathy Emswiller  The resident has to verbal, sexual, physicorporal punishments seclusion.  The facility must no sexual, or physical punishment, or involved facility failed to a from physical above reviewed for allessample of 10 religible the resident into a sliding back to the CNA #3 in the recinitervene to protect (Resident #D, CNA #3)  Findings included  The record for Recond 5/16/11 at 11: included, but we hypertension, den	the right to be free from ysical, and mental abuse, ent, and involuntary  of use verbal, mental, I abuse, corporal voluntary seclusion.  review and interview the ensure a resident was free use for 1 or 2 residents gations of abuse in a ated to CNA #1 pushing a chair and the chair ne wall with CNA #2 and from and failed to eet the resident.  NA #1, CNA #2, and  d:  esident #D was reviewed 20 a.m. Her diagnoses	F0	223	Allegation of Credible Compliance. This plan of correction is prepared and executed because it is requir by the provision of State and Federal law and not because Timberview Health Care Cen agrees with the allegations a citations listed in this stateme deficiency. Timberview Heal Care Center maintains that the alleged deficiencies do not individually or collectively jeopardize the health and sat of the residents, nor are they such character so as to limit capability to render adequate care. This plan of correction also operate as the facility's written credible allegation of compliance. #1 What correct actions will be accomplished those residents found to have been affected by the deficient	enter nd ent of ent of eth our eshall tive for e	06/16/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155580 05/17/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2350 TAFT STREET TIMBERVIEW HEALTH CARE CENTER **GARY. IN46404** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Disease. practice? Resident #D was assessed for injuries with no injuries noted. Social Service A progress note dated 4/29/11 at 9:13 also assessed resident #D for any a.m., indicated resident was sitting in abnormal findings with psychosocial well being. No south dining room when staff member abnormal findings noted. went to take another resident's tray. The Resident's #D primary doctor and resident thought staff member had said family were notified of something to her when this resident got occurrence. ISDH, Adult upset and jumped up and grab the staff Protective Services, and local police were also notified of member by her neck. The resident was occurrence. The certified immediately removed from staff and sat in nursing assistants, #1, #2, and #3 chair. When nurse arrived in dining room had all received training on the resident was sitting in chair. The nurse facility policy related to abuse and reporting of abuse. They were offered resident to take a walk but well aware of the facility policies resident refused. Resident indicated she and chose to violate those just wanted to sit in the chair. Resident policies. The conduct of these individuals was absolutely had no injury and resident was pleasant unacceptable to Administration of with staff and other residents at this time. this facility and CNA #1, #2 and Resident's family and physician made #3 were terminated. #2 How will aware. other residents having the potential to be affected by the same deficient practice be A progress note dated 4/29/11 at 13:34 identified and what corrective (1:34 p.m.), indicated nurse was told by actions will be taken? As identified staff there was an altercation between by facility policy, all residents resident and staff. This incident was have the right to be free from verbal, sexual, physical, and initiated by staff. Resident was relaxing mental abuse, involuntary in chair at this time. Body assessment seclusion, corporal punishment done, no new injuries noted. No and misappropriateion of resident complaints of pain or discomfort. property. Thus, all residents have the potential to be affected by the Resident alert and pleasant with staff and same deficient practice. All other residents. residents will be interviewed and assessed for any verbal reports, A reportable incident was provided by the signs, and symptoms of abuse. Any abnormal findings will be Administrator and reviewed on 5/16/11 at

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<b>l</b> i '		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155580	B. WIN	G		05/17/2011
NAME OF I	PROVIDER OR SUPPLIER		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	FROVIDER OR SUFFLIER			2350 TA	AFT STREET	
TIMBER	VIEW HEALTH CAR	E CENTER		GARY,	IN46404	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	8:00 p.m. The in	cident involved Resident			investigated and reported as	I
	#D and CNA #1,	CNA #2, and CNA #3.			required by ISDH guidelines What measures will be put ir	
					place or what systemic chan	
	"On April 29, 20	11, (CNA#1's name)			will be made to ensure that t	
	reported to the nu	arse that at approximately			deficient practice does not re	ecur?
	9:00 a.m., while	assisting residents in the			On 4/29/11 Nursing personn	
		sident #D's name), had			were immediately inserviced	
	been swearing at	* *			the facility abuse policy. On 5/3/11 additional inservices with the facility abuse policy.	I
	1	ssive and grabbed her by			held related to the facility ab	
	the throat. The n	•			policy. The Ombudsman als	
					provided inservices for staff	
	_	orted to management.			related to resident rights and	I
		nediate investigations			caring for residents with	
	1	esident to staff abuse and			aggressive behaviors. A	
	found that the sta	aff member, (CNA #1's			mandatory inservice for all si will be given on identification	
	name), provoked	the resident and that the			abuse and reporting of abuse	
	resident, while go	oing after (CNA #1's			Inservice training will be	o.
	name), did not gr	ab (CNA #1's name) by			completed no later than June	e 16,
	· · · · · ·	eems to have been			2011. #4 How will the correc	tive
		conversation (CNA #1's			actions be monitored to ensu	
	I -	g with her. This was			the deficient practice will not	
		leo surveillance. Video			recur? A Quality Assurance A Tool will be utilized by Social	
	·				Services or Designee to aud	
		showed that (CNA #2's			any reports of signs or symp	
		A #3's name) were present			of abuse from 5 resident per	
		d not seek assistance or			week for three months then	
	intervene in this				residents monthly, therafter.	- 1
	Based on our init	ial investigation, (CNA			concerns will be reported to	
	#1's name), (CNA	A #2's name), and (CNA			administrator immediately fo further investigation. Report	
	#3's name) were	suspended immediately			ISDH will be made as require	
	pending further in	•			regulations. Unit	
		d family were notified			Managers/designee will sele	
	and the resident h	_			staff members each week fo	
		nd #3's name) have been			weeks and then 5 staff mem	bers
	terminated."	ia mo o namej nave ucen			monthly for 3 months on	
					interviewing on abuse and reporting of abuse and quart	erly
	There was no inju	ury notea.			1 Toporting or abuse and quart	,

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	INSTRUCTION 00	(X3) DATE COMPL		
ANDILAN	OF CORRECTION	155580	A. BUI			05/17/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				AFT STREET		
TIMBER	VIEW HEALTH CAR	E CENTER	GARY, IN46404				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	,	to will	DATE
	date was April 29 alleged that (Resiher by the throat. immediate invest observed handlin rough and inappr (CNA #2's name) were present in the event. The staff is suspended pendin investigation."  A mood/behavior with the investigation completed by (CI (CNA #1's name) (sic) room pickin pick up a residen (Resident #D's nasaid your welcom name) started curt to get the toul (sic and that's when significant pick up and grupped when she did that	report sheet provided			thereafter. Findings of resul be submitted for Quality Assurance Review and any concerns addressed.	ts will	
	the noise and can	ne right in to see what					
	had happened.						
	Actions form for	ounseling and Corrective CNA #1 indicated and time of occurrence:					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155580	B. WIN	G		05/17/2	011
NAME OF	PROVIDER OR SUPPLIER	<u>"</u> }		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				1	AFT STREET		
TIMBER	VIEW HEALTH CAF	RE CENTER		GARY, I	IN46404		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ent: allegation of abuse					
	has been substan	itiated.					
	A Progressive Co	ounseling and Corrective					
	1 ~	: CNA #2 indicated a date					
		irrence was 4/29/11.					
	1	nination for failing to					
	1	atient abuse in the special					
	care unit dining	100111.					
	A Progressive Co	ounseling and Corrective					
	1	CNA #3 indicated a date					
		rrence was 4/29/11.					
		nination for failing to					
		atient abuse in the special					
	care unit dining	•					
	care unit uning	100111.					
	The Abuse, Negl	lect, and					
	"	n of Resident Property					
		edure was provided by the					
	I -	n 5/16/11 at 3:40 p.m.					
		olicy is that the resident					
	1	be free from verbal,					
	1	and mental abuse,					
	involuntary secl						
	1 -	misappropriation of					
	1 ^	in accordance with all					
	1	ederal regulations.					
	1 ' '	not be subjected to abuse					
	1	ding but not limited to,					
	1 * *	er residents, consultants					
		aff of other agencies					
		ent, family members or					
	legal guardians,						

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	INSTRUCTION	(X3) DATE :	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155580	A. BUI	LDING	00	05/17/2	
		100000	B. WIN			03/11/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
TIMBER	VIEW HEALTH CAR	F CENTER		1	IN46404		
		TATEMENT OF DEFICIENCIES		ID			(7/5)
(X4) ID PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	individuals."						
		rpose is to ensure that					
	resident rights are protected by providing						
		estigation and reporting					
		of mistreatment, neglect,					
	ı	injuries of unknown					
	source, unusual c	_					
		of resident property.					
	Definitions	1 1 7					
	Abuse: "The wil	lful infliction of injury,					
		finement, intimidations					
		ith resulting physical					
	pain or mental ar	nguish. This also					
	l ^	rivation by an individual,					
	_	aker, of goods or services					
	I -	y to attain or maintain					
	1	and psychosocial					
		presumes that instances					
	of abuse of all re	sidents, even those in a					
	coma, cause phys	sical harm, or pain or					
	mental anguish."						
	Physical abuse:	"Includes hitting,					
	slapping, pinchin	g and kicking. It also					
	1 11 0 1	ing behavior through					
	corporal punishm						
	Interview with th	e Administrator on					
	5/16/11 at 12:55	a.m., indicated when she					
	heard the allegati	ions of Resident #D's					
	behavior she thou	ught something just was					
	not right. She wa	atched the surveillance					
	video and saw w	hat had happened.					
	Resident #D spill	led drink on pants. CNA					
	#1 came over and	d there were words. CNA					

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:			(X2) MULTIPLE CO		(X3) DATE SURVEY  COMPLETED
AND PLAIN	OF CORRECTION	155580	A. BUILDING	00	05/17/2011
		.0000	B. WING	ADDRESS, CITY, STATE, ZIP CODE	1 00/11/2011
NAME OF F	PROVIDER OR SUPPLIER		l	AFT STREET	
	/IEW HEALTH CAR		GARY,	IN46404	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
		CNA #1 was seen talking			
	,	CNA #3 and she appeared			
		ve an attitude. CNA #1			
	-	ident #D and was			
	_	er at her. The resident			
		away. All of this time			
	_	peing said. Resident # D			
		es a hand out to grab			
	CNA #1 at which	time CNA #1 pushes the			
	resident who fall	s back into her chair and			
	the chair goes ba	ck against the wall.			
		e Director of Nursing on			
		a.m., indicated she was			
		she viewed the video			
	•	she saw the tape she			
		nted all three of the staff			
	members out of t	he facility immediately.			
	This Federal tag	relates to Complaint			
	IN00090300.	r			
	3.1-27(a)(1)				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155580	B. WING			05/17/2	011
			B. WILL		DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	-			AFT STREET		
TIMBER	/IEW HEALTH CAR	E CENTER		GARY, I			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0225 SS=D	have been found of or mistreating residence had a finding nurse aide registry mistreatment of residence of their property; a has of actions by a employee, which we service as a nurse	ot employ individuals who guilty of abusing, neglecting, dents by a court of law; or a entered into the State or concerning abuse, neglect, sidents or misappropriation and report any knowledge it a court of law against an would indicate unfitness for a aide or other facility staff to de registry or licensing					
	violations involving abuse, including ir and misappropriat reported immediat the facility and to d with State law thro	nsure that all alleged g mistreatment, neglect, or njuries of unknown source ion of resident property are ely to the administrator of other officials in accordance ough established procedures tate survey and certification					
	alleged violations	ave evidence that all are thoroughly investigated, further potential abuse while in progress.					
	reported to the addrepresentative and accordance with S State survey and oworking days of the violation is verified action must be take				#4 Milest competitive activi	::II b. a	
	facility failed to a physical abuse of Administrator for		F0:	225	#1 What corrective actions w accomplished for those resid found to have been affected the deficient practice? Resid #D was assessed for injuries no injuries noted. Social Ser	ents by lent with	06/16/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155580	B. WIN			05/17/2	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF			2350 TA	AFT STREET		
	VIEW HEALTH CAF	RE CENTER			IN46404		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG	-	LSC IDENTIFYING INFORMATION)	+	TAG			DATE
	sample of 10 related to CNA #1 pushing				also assessed resident #D fo abnormal findings with	or arry	
		a chair and the chair			psychosocial well being. No		
	_	ne wall with CNA #2 and			abnormal findings noted.		
	CNA #3 in the ro	oom failed to intervene to			Resident's #D primary docto	r and	
	protect the reside	ent. (Resident #D, CNA			family were notified of		
	#1, CNA #2, and	I CNA #3)			occurrence. ISDH, Adult		
					Protective Services, and loca police were also notified of	11	
	Findings include	ed:			occurrence. The certified		
					nursing assistants, #1, #2, a	nd #3	
	The record for R	esident #D was reviewed			had all received training on the		
		20 a.m. Her diagnoses			facility policy related to abuse		
		re not limited to,			reporting of abuse. They we well aware of the facility police		
	1	mentia with behaviors,			and chose to violate those	JIES	
		a, and Alzheimer's			policies. The conduct of the	se	
	Disease.	a, and Alzhenner s			individuals was absolutely		
	Disease.				unacceptable to Administration		
					this facility and CNA #1, #2 a		
	1 .	inimum Data Set			#3 were terminated. #2 How other residents having the	WIII	
		d 5/2/11, indicated the			potential to be affected by the	e	
		lerstood and understands.			same deficient practice be	_	
		n her Brief Interview of			identified and what corrective		
		This indicated the resident			actions will be taken?As ider		
	was severely imp	paired cognitively.			by facility policy, all residents have the right to be free from		
					verbal, sexual, physical, and	'	
	A progress note	dated 4/29/11 at 9:13			mental abuse, involuntary		
	a.m., indicated re	esident was sitting in			seclusion, corporal punishme		
	south dining roo	m when staff member			and misappropriateion of res		
	1	ther resident's tray. The			property. Thus, all residents		
		staff member had said			the potential to be affected b same deficient practice. All	y u i <del>e</del>	
	1	when this resident got			residents will be interviewed	and	
	_	d up and grab the staff			assessed for any verbal repo	orts,	
	1	neck. The resident was			signs, and symptoms of abus		
	1	noved from staff and sat in			Any abnormal findings will be		
	1	rse arrived in dining room			investigated and reported as required by ISDH guidelines.		
		ing in chair. The nurse			What measures will be put in		
	Licsident was sittle	ing in chan. The hulse				-	

008505

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155580 05/17/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2350 TAFT STREET TIMBERVIEW HEALTH CARE CENTER **GARY. IN46404** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE offered resident to take a walk but place or what systemic changes will be made to ensure that the resident refused. Resident indicated she deficient practice does not recur? just wanted to sit in the chair. Resident On 4/29/11 Nursing personnel had no injury and resident was pleasant were immediately inserviced on the facility abuse policy. On with staff and other residents at this time. 5/3/11 additional inservices were Resident's family and physician made held related to the facility abuse aware. policy. The Ombudsman also provided inservices for staff A progress note dated 4/29/11 at 13:34 related to resident rights and caring for residents with (1:34 p.m.), indicated nurse was told by aggressive behaviors. A staff there was an altercation between mandatory inservice for all staff resident and staff. This incident was will be given on identification of initiated by staff. Resident was relaxing abuse and reporting of abuse. Inservice training will be in chair at this time. Body assessment completed no later than June 16, done, no new injuries noted. No 2011. #4 How will the corrective complaints of pain or discomfort. actions be monitored to ensure the deficient practice will not Resident alert and pleasant with staff and recur? A Quality Assurance Audit other residents. Tool will be utilized by Social Services or Designee to audit for A reportable incident was provided by the any reports of signs or symptoms Administrator and reviewed on 5/16/11 at of abuse from 5 resident per week for three months then 5 8:00 p.m. The incident involved Resident residents monthly, therafter. Any #D and CNA #1, CNA #2, and CNA #3. concerns will be reported to the administrator immediately for "On April 29, 2011, (CNA#1's name) further investigation. Reports to ISDH will be made as required by reported to the nurse that at approximately regulations. Unit 9:00 a.m., while assisting residents in the Managers/designee will select 5 dining room, (Resident #D's name), had staff members each week for 4 been swearing at her and became weeks and then 5 staff members monthly for 3 months on physically aggressive and grabbed her by interviewing on abuse and the throat. The nurse assessed the reporting of abuse and quarterly situation and reported to management. thereafter. Findings of results will We began an immediate investigations be submitted for Quality Assurance Review and concerns into the alleged resident to staff abuse and

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Event ID:

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155580	B. WIN			05/17/2	011
NAME OF S	DROLLIDED OD GLIDDLIEF	\		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	C		2350 TA	AFT STREET		
	VIEW HEALTH CAF				IN46404		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, i	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)	+	TAG	addressed.		DATE
		aff member, (CNA #1's			addressed.		
	/ 1	I the resident and that the					
	1	oing after (CNA #1's					
	1 -	rab (CNA #1's name) by					
		seems to have been					
		conversation (CNA #1's					
	1 '	ng with her. This was					
	1	deo surveillance. Video					
	surveillance also	showed that (CNA #2's					
	name), and (CN	A #3's name) were present					
	in the area and d	id not seek assistance or					
	intervene in this	situation.					
	Based on our ini	tial investigation, (CNA					
	#1's name), (CN	A #2's name), and (CNA					
	#3's name) were	suspended immediately					
	pending further i	•					
	1 ^	nd family were notified					
	and the resident	-					
		nd #3's name) have been					
	terminated."						
	There was no inj	jury noted					
	There was no my	ary notes.					
	The initial report	t indicated the incident					
	1 *	9, 2011. "Staff member					
	1 *	sident #D's name) grabbed					
		. However, during our					
	1	tigation CNA was					
	1	ng treating resident in a					
	1	ropriate manner while					
	1	and (CNA #3's name)					
	1 '	the area and witnessed the					
	1 ^	noted above were all					
	suspended pendi						
	1 -	ing outcome of					
	investigation."						

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/13/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE COMPL	
AND PLAN	OF CORRECTION	155580	A. BUI		00	05/17/2	
		100000	B. WIN		ADDRESS OF VICTATE ZIR CODE	00/11/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
TIMBER	VIEW HEALTH CAR	E CENTER		1	IN46404		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	with the investigated completed by CN #1's name) was in room picking up resident's name to name) said thank welcome, and (R started cursing mathet oul (sic) from that's when she (did that and sat her in the the noise and can had happened.  A counseling/Conducted 4/29/11 for suspension pendictions.	NA #1, indicated "I (CNA in the south dinning (sic) trays. I went to pick up a ray, and (Resident #D's rayou. I said your resident #D's name) are out. So I went to get in a resident sname and Resident #D's name) rabbed me by the throat. It I grabbed her hands rechair. The nurse heard in right in to see what it is considered and abuse investigation.					
		rrective Action Form CNA #3, indicated					
		ng abuse investigation.					
		mments: "refused to					
	write statement."						
	Actions form for termination, date	ounseling and Corrective r CNA #1 indicated and time of occurrence: ent: allegation of abuse					

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Facility ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED
		155580	B. WIN			05/17/2	011
		<u> </u>	P		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			AFT STREET		
TIMBER'	VIEW HEALTH CAF	RE CENTER		1	IN46404		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	has been substan	itiated.					
	A Progressive C	ounseling and Corrective					
	_	: CNA #2 indicated a date					
		errence was 4/29/11.					
		nination for failing to					
	_	atient abuse in the special					
	care unit dining	room.					
	A Progressive Co	ounseling and Corrective					
	_	CNA #3 indicated a date					
		arrence was 4/29/11.					
		nination for failing to					
	1	atient abuse in the special					
	care unit dining	room.					
	The Abuse, Neg	lect, and					
	1	n of Resident Property					
	_ ^ ^	edure was provided by the					
	<u> </u>	n 5/16/11 at 3:40 p.m.					
		olicy is that the resident					
		be free from verbal,					
	_	and mental abuse,					
	1	•					
	involuntary secl	• •					
	1 *	misappropriation of					
		in accordance with all					
		Pederal regulations.					
		not be subjected to abuse					
	1 ' '	ding but not limited to,					
	_ ·	er residents, consultants					
		aff of other agencies					
	serving the resid	ent, family members or					
	legal guardians,						
	individuals."						
	•		-		•		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155580		A. BUII	LDING	NSTRUCTION  00	(X3) DATE S COMPL <b>05/17/2</b>	ETED	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	₹			AFT STREET		
	VIEW HEALTH CAF			<u> </u>	N46404		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL  LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TΕ	COMPLETION DATE
1710	•	rpose is to ensure that	1	1710			DITTE
	1	re protected by providing					
		restigation and reporting					
	1	of mistreatment, neglect,					
	1	injuries of unknown					
	source, unusual	_					
	1	n of resident property.					
	Definitions	1 1 3					
	Abuse: "The wi	llful infliction of injury,					
	unreasonable co	nfinement, intimidations					
	or punishment w	vith resulting physical					
	pain or mental a	nguish. This also					
	includes the dep	rivation by an individual,					
	including a caret	taker, of goods or services					
	that are necessar	y to attain or maintain					
	physical, mental	and psychosocial					
	well-being. This	s presumes that instances					
	of abuse of all re	esidents, even those in a					
	coma, cause phy	sical harm, or pain or					
	mental anguish.'						
	1 -	"Includes hitting,					
	1 11 0 1	ng and kicking. It also					
	1	ling behavior through					
	corporal punishr						
		tion and Implementation					
	1	s not limited to, "the					
	1	sure that all allegations of					
	1	eglect or abuse, including					
	1 *	own source, are reported					
	1	he Administrator of the					
	facility and to ot						
	1	sate law through					
	established proc						
	when incidents	involving suspected					

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155580	B. WING		05/17/2011
NAME OF I	PROVIDER OR SUPPLIER		STREE	T ADDRESS, CITY, STATE, ZIP CODE	
			I	TAFT STREET	
IIMBER	VIEW HEALTH CAR	RE CENTER	GAR	Y, IN46404	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX	``	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENC!)	DATE
		mistreatment including			
	_	facility shall take the			
		"If resident sustains			
		ployee or employee is			
		rator: remove the			
	1 * *	liately. Staff is to notify			
	1	visor and he or she must			
	resident."	w with employee and			
	resident.				
	Interview with the	ne Administrator on			
		a.m., indicated when she			
		ions of Resident #D's			
	_				
		ught something just was atched the surveillance			
	1				
		hat had happened.			
	_	led drink on pants. CNA d there were words. CNA			
		CNA #1 was seen talking			
	-	CNA #1 was seen talking CNA #3 and she appeared			
		ve an attitude. CNA #1			
	_	sident #D and was			
	~	ger at her. The resident			
		away. All of this time			
	1 ^	being said. Resident # D			
		es a hand out to grab			
		h time CNA #1 pushes the			
		s back into her chair and			
		ick against the wall. It			
	_	eated that were CNA #2			
		re interviewed in regard to			
		ner of the employees			
		ing in regard to the			
	incident.	ing in regard to the			
	meraciit.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION 00	(X3) DATE SURVEY  COMPLETED
		155580	B. WING		05/17/2011
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
	/IEW HEALTH CAR		I	IN46404	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
F0226 SS=D	5/17/11 at 11:00 every upset when tape. As soon as indicated she was members out of the tape. As soon as indicated she was members out of the tape. This Federal tage IN00090300.  3.1-28(c)  The facility must downitten policies and misappropriate Based on record facility failed to inprocedure related to the Administrate reviewed for allessample of 10 relative to the resident into a sliding back to the CNA #3 in the rolative intervene to protect (Resident #D, CNA #3)  Findings included	ect the resident. NA #1, CNA #2, and	F0226	#1 What corrective actions we accomplished for those reside found to have been affected the deficient practice? Reside #D was assessed for injuries no injuries noted. Social Seralso assessed resident #D for abnormal findings with psychosocial well being. No abnormal findings noted. Resident's #D primary doctor family were notified of occurrence. ISDH, Adult Protective Services, and location police were also notified of occurrence. The certified nursing assistants, #1, #2, and all received training on the facility policy related to abuse reporting of abuse. They we	ents by lent with vice or any  r and  al  al  al  ae e and

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPL	ETED
		155580	B. WIN			05/17/2	011
		1	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	₹		1	AFT STREET		
TIMBER	VIEW HEALTH CAF	RE CENTER		1	IN46404		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	<b>+</b>	LISC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		:20 a.m. Her diagnoses			well aware of the facility poli and chose to violate those	cies	
	1	ere not limited to,			policies. The conduct of the	se.	
	1 - 1	ementia with behaviors,			individuals was absolutely		
	anxiety, insomn	ia, and Alzheimer's			unacceptable to Administrat	ion of	
	Disease.				this facility. CNA #1, #2 and		
					were terminated. #2 How wi	II	
	The quarterly M	inimum Data Set			other residents having the potential to be affected by the	ne.	
	Assessment date	ed 5/2/11, indicated the			same deficient practice be		
		lerstood and understands.			identified and what corrective	е	
	She scored a 4 o	n her Brief Interview of			actions will be taken?As ide		
		Γhis indicated the resident			by facility policy, all resident		
		paired cognitively.			have the right to be free from		
	was severely ini	paned cognitively.			verbal, sexual, physical, and mental abuse, involuntary	1	
	A mma amaga mata	datad 4/20/11 at 0:12			seclusion, corporal punishm	ent	
		dated 4/29/11 at 9:13			and misappropriateion of re-		
		esident was sitting in			property. Thus, all residents		
	1	m when staff member			the potential to be affected by	by the	
		ther resident's tray. The			same deficient practice. All residents will be interviewed	land	
	1	staff member had said			assessed for any verbal rep		
	_	r when this resident got			signs, and symptoms of abu		
	upset and jumpe	d up and grab the staff			Any abnormal findings will b		
	member by her i	neck. The resident was			investigated and reported as		
	immediately ren	noved from staff and sat in			required by ISDH guidelines		
	chair. When nu	rse arrived in dining room			What measures will be put i place or what systemic char		
	resident was sitt	ing in chair. The nurse			will be made to ensure that	-	
		to take a walk but			deficient practice does not r		
		Resident indicated she			On 4/29/11 Nursing personr		
		t in the chair. Resident			were immediately inserviced		
	1 "	d resident was pleasant			the facility abuse policy. Or 5/3/11 additional inservices		
	1 3 5	her residents at this time.			held related to the facility ab		
		y and physician made			policy. The Ombudsman al		
	1	y and physician made			provided inservices for staff		
	aware.				related to resident rights and	t	
	A	d-4-1 4/20/11 -4 12:24			caring for residents with		
		dated 4/29/11 at 13:34			aggressive behaviors. A mandatory inservice for all s	taff	
	[ (1:34 p.m.), ındı	cated nurse was told by			manuatory mservice for all s	ıdıı	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155580 05/17/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2350 TAFT STREET TIMBERVIEW HEALTH CARE CENTER **GARY. IN46404** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE will be given on identification of staff there was an altercation between abuse and reporting of abuse. resident and staff. This incident was Inservice training will be initiated by staff. Resident was relaxing completed no later than June 16, in chair at this time. Body assessment 2011. #4 How will the corrective actions be monitored to ensure done, no new injuries noted. No the deficient practice will not complaints of pain or discomfort. recur? A Quality Assurance Audit Resident alert and pleasant with staff and Tool will be utilized by Social other residents. Services or Designee to audit for any reports of signs or symptoms of abuse from 5 resident per A reportable incident was provided by the week for three months then 5 Administrator and reviewed on 5/16/11 at residents monthly, therafter. Any 8:00 p.m. The incident involved Resident concerns will be reported to the #D and CNA #1, CNA #2, and CNA #3. administrator immediately for further investigation. Reports to ISDH will be made as required by "On April 29, 2011, (CNA#1's name) regulations. Unit reported to the nurse that at approximately Managers/designee will select 5 staff members each week for 4 9:00 a.m., while assisting residents in the weeks and then 5 staff members dining room, (Resident #D's name), had monthly for 3 months on been swearing at her and became interviewing on abuse and physically aggressive and grabbed her by reporting of abuse and quarterly the throat. The nurse assessed the thereafter. Findings of results will be submitted for Quality situation and reported to management. Assurance Review and any We began an immediate investigations concerns addressed. into the alleged resident to staff abuse and found that the staff member, (CNA #1's name), provoked the resident and that the resident, while going after (CNA #1's name), did not grab (CNA #1's name) by the throat. She seems to have been reacting to some conversation (CNA #1's name) was having with her. This was confirmed by video surveillance. Video surveillance also showed that (CNA #2's name), and (CNA #3's name) were present

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155580		(X2) MI A. BUII B. WIN	LDING	nstruction 00	(X3) DATE S COMPL 05/17/2	ETED	
NAME OF	PROVIDER OR SUPPLIER	<b>1</b>		STREET A	AFT STREET		
TIMBER	VIEW HEALTH CAF	RE CENTER		1	N46404		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	intervene in this Based on our ini #1's name), (CN #3's name) were pending further in The physician are and the resident "(CNA #1, #2, atterminated." There was no inj.  The initial report date was April 2 alleged that (Resident was April 2 alleged that (Resident by the throat immediate investigation and inapping (CNA #2's name were present in the event. The staff suspended penditinvestigation."  A mood/behavior with the investigation completed by CM #1's name) was in room picking up resident's name in name) said thank welcome, and (Resident).	tial investigation, (CNA A #2's name), and (CNA suspended immediately investigation.  Ind family were notified has no injuries."  Ind #3's name) have been fury noted.  It indicated the incident 19, 2011. "Staff member sident #D's name) grabbed. However, during our tigation CNA was no treating resident in a ropriate manner while and (CNA #3's name) he area and witnessed the noted above were all no outcome of					

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITE	LDING	00	COMPI	LETED
		155580	B. WIN			05/17/2	011
		1	B. WII		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEI	R		1	AFT STREET		
TIMBER	VIEW HEALTH CAR	RE CENTER		1	IN46404		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	<del> </del>	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	the toul (sic) fro	m a resident's name and					
	that's when she	(Resident #D's name)					
	jumped up and g	grabbed me by the throat.					
	When she did th	at I grabbed her hands					
	and sat her in the	e chair. The nurse heard					
		me right in to see what					
	had happened.						
	nad nappened.						
	A counceling/Ca	orrective Action Form					
	1						
	1	r CNA #2, indicated					
	1	ling abuse investigation.					
		mments: "refused to					
	write statement.	"					
	A counseling/Co	orrective Action Form					
	1						
		r CNA #3, indicated					
	1 ^ ^	ling abuse investigation.					
		omments: "refused to					
	write statement.	II					
	A Progressive C	ounseling and Corrective					
	_	or CNA #1 indicated					
		e and time of occurrence:					
	1						
	1	ent: allegation of abuse					
	has been substar	ntiated.					
	A Progressive C	ounseling and Corrective					
	_	r CNA #2 indicated a date					
		arrence was 4/29/11.					
	1	nination for failing to					
	1	atient abuse in the special					
	care unit dining	room.					
		1. 1.6					
	A Progressive C	ounseling and Corrective					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155580	B. WIN			05/17/2011	
NAME OF F	PROVIDER OR SUPPLIER	•	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
				1	AFT STREET		
TIMBER	VIEW HEALTH CAR	RE CENTER		GARY,	IN46404		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE	
		CNA #3 indicated a date					
		rrence was 4/29/11.					
		nination for failing to					
	_	atient abuse in the special					
	care unit dining i	room.					
	The Abuse, Negl						
		n of Resident Property					
	1 *	dure was provided by the					
		1 5/16/11 at 3:40 p.m.					
	"This facility's po	olicy is that the resident					
	has the right to b	e free from verbal,					
	sexual, physical	and mental abuse,					
	involuntary secl	usion, corporal					
	punishment and	misappropriation of					
	resident property	in accordance with all					
	stated (sic) and for	ederal regulations.					
	Residents must n	ot be subjected to abuse					
	by anyone, inclu	ding but not limited to,					
	facility staff, other	er residents, consultants					
	or volunteers, sta	aff of other agencies					
	serving the reside	ent, family members or					
	legal guardians, i						
	individuals."						
	"This policy's pu	rpose is to ensure that					
		e protected by providing					
	a method for inv	estigation and reporting					
		of mistreatment, neglect,					
	_	injuries of unknown					
	source, unusual o	•					
		of resident property.					
	Definitions						
		Ilful infliction of injury,					
		nfinement, intimidations					
		,			l		—

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE COMPI		
AND PLAN	OF CORRECTION	155580	A. BUI	LDING	00	05/17/2	
		133300	B. WIN			03/11/2	.011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE  AFT STREET		
TIMBER\	VIEW HEALTH CAR	E CENTER		1	IN46404		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	· · · · · · · · · · · · · · · · · · ·		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	or punishment w	ith resulting physical					
	pain or mental ar	nguish. This also					
	includes the depr	rivation by an individual,					
	including a careta	aker, of goods or services					
	that are necessary	y to attain or maintain					
		and psychosocial					
	_	presumes that instances					
		sidents, even those in a					
	1 1	sical harm, or pain or					
	mental anguish."						
	l *	"Includes hitting,					
		g and kicking. It also					
		ing behavior through					
	corporal punishm						
		tion and Implementation					
	· ·	s not limited to, "The					
		nmit verbal, mental,					
		al abuse, including					
		nent or involuntary					
		facility's will ensure that					
		mistreatment, neglect or					
		injuries of unknown					
		ted immediately to the					
		the facility and to other					
		dance with sate law					
	through establish	-					
		nvolving suspected					
	_	mistreatment including					
		facility shall take the					
		"If resident sustains					
	• • • • •	loyee or employee is					
		rator: remove the					
		liately. Staff is to notify					
	immediate super	visor and he or she must					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

F8PO11

Facility ID:

008505

If continuation sheet

Page 23 of 31

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/13/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	NSTRUCTION 00	COI	MPLETED	
		155580	B. WIN				7/2011
NAME OF F	PROVIDER OR SUPPLIER			1	.DDRESS, CITY, STATE, ZIP ( AFT STREET	CODE	
TIMBER	VIEW HEALTH CAR	E CENTER		GARY, I			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CO	ADDECTION	(X5)
PREFIX	` ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		w with employee and					
	resident."						
	Interview with th	e Administrator on					
	5/16/11 at 12:55	a.m., indicated when she					
	heard the allegati	ions of Resident #D's					
	behavior she thou	ught something just was					
	not right. She wa	atched the surveillance					
		hat had happened.					
	•	led drink on pants. CNA					
		d there were words. CNA					
		CNA #1 was seen talking					
		CNA #3 and she appeared					
	-	ve an attitude. CNA #1					
	_	ident #D and was er at her. The resident					
		away. All of this time					
	•	being said. Resident # D					
		es a hand out to grab					
		time CNA #1 pushes the					
		s back into her chair and					
	the chair goes ba	ck against the wall. It					
		ated that were CNA #2					
		e interviewed in regard to					
		ner of the employees					
		ng in regard to the					
	incident.						
	Interview with th	e Director of Nursing on					
		a.m., indicated she was					
		she viewed the video					
		she saw the tape she					
	indicated she was	nted all three of the staff					
	members out of t	he facility immediately.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

F8PO11

Facility ID:

008505

If continuation sheet

Page 24 of 31

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					URVEY	
OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDIN	NG	00	COMPL	ETED
	155580				05/17/20	011
		S' 2	350 TA	FT STREET		
SUMMARY S	TATEMENT OF DEFICIENCIES	ID		DROWINED'S DLAN OF CORDECTION		(X5)
(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PRE	EFIX	(EACH CORRECTIVE ACTION SHOULD BE	. I	COMPLETION
REGULATORY OR	LSC IDENTIFYING INFORMATION)	T	AG	DEFICIENCY)		DATE
This Federal tag IN00090300. 3.1-28(a)	relates to Complaint					
assessment to deveresident's comprehensive as The care plan must are to be furnished resident's highest mental, and psychosocial orecident's highest mental, and psychosocial orecident orecident orecident orecident orecident orecord originate or residents or residents reviewed elopement in a safety.  Findings includes	velop, review and revise the nensive plan of care.  evelop a comprehensive resident that includes tives and timetables to meet al, nursing, and mental and its that are identified in the sessment.  St describe the services that it to attain or maintain the practicable physical, osocial well-being as 33.25; and any services that it e required under §483.25 and due to the resident's under §483.10, including the timent under §483.10(b)(4). The view and interview the develop plans of care sidents for 1 of 3 and who were at risk for ample of 10. (Resident	F027	9	accomplished for those residence found to have been affected the deficient practice? The caplan for resident #C has been updated to reflect current need of this resident. #2 How will coresidents having the potential be affected by the same deficient practice will be identified and what corrective action will be taken? The care plans for other the deficience of the same deficience of the same deficience will be identified and what corrective action will be taken? The care plans for other the deficience of the same deficienc	ents by are n eds other I to cient	06/16/2011
The record for Ro	esident #C was reviewed					
	PROVIDER OR SUPPLIER  SUMMARY S  (EACH DEFICIENT REGULATORY OR  This Federal tag IN00090300.  3.1-28(a)  A facility must use assessment to deversident's compreled a resident's medic psychosocial needs comprehensive as  The care plan must are to be furnished resident's highest mental, and psychosocial needs comprehensive as  The care plan must are to be furnished resident's highest mental, and psychosocial needs comprehensive as  The care plan must are to be furnished resident's highest mental, and psych required under \$44 would otherwise be but are not provide exercise of rights or right to refuse treat Based on record facility failed to a specific to the residents reviewed elopement in a safety.  Findings include	IDENTIFICATION NUMBER: 155580  ROVIDER OR SUPPLIER  //EW HEALTH CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  This Federal tag relates to Complaint IN00090300.  3.1-28(a)  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review and interview the facility failed to develop plans of care specific to the residents for 1 of 3 residents reviewed who were at risk for elopement in a sample of 10. (Resident	DENTIFICATION NUMBER: 155580  ROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  This Federal tag relates to Complaint IN00090300.  3.1-28(a)  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  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WING	ROVIDER OR SUPPLIER  ROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY PLIL. REGULATORY OR LSC IDENTIFYING INFORMATION)  This Federal tag relates to Complaint IN00090300.  3.1-28(a)  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under \$483.25, and any services that would otherwise be required under \$483.25 but are not provided due to the resident's exercise of rights under \$483.10(b)(4).  Based on record review and interview the facility failed to develop plans of care specific to the residents for 1 of 3 residents reviewed who were at risk for elopement in a sample of 10. (Resident #C)  #1 What corrective actions w accomplished for those resid found to have been affected for this resident. #2 how will or residents having the potential be affected by the same defic practice will be identified and what corrective action will be affected by the same defic practice will be identified and what corrective action will be	ROVIDER OR SUPPLIER  ROVIDER OR SUPPLIER  RIEW HEALTH CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MIST BE PERCEDED BY FULL  REGULATORY OR I.S.C IDENTIFYING INFORMATION)  This Federal tag relates to Complaint IN00090300.  3.1-28(a)  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's emperational psychosocial well-being as required under \$483.75, and any services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under \$483.25, and any services that are not provided due to the resident's exercise of rights under \$483.10, including the right to refuse treatment u

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SUR		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETE	D	
		155580	B. WIN			05/17/2011		
				STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIER			2350 TA	AFT STREET			
	VIEW HEALTH CAR	E CENTER			IN46404			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E CC	OMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG			DATE	
		46 a.m. The resident's			assessed for high risk for elopement have been review	ed		
	_	ed, but was not limited			and updated. #3 What meas			
	1	l status, hypertension,			will be put into place or what			
	dementia, and his	story of head trauma.			systemic changes will be ma			
					ensure that the deficient prac	tice		
	Review of the qu	arterly Minimum Data			does not recur?Based on			
	Set Assessment d	lated 4/18/11, indicated			elopement risk assessment triggers, careplan approache	s will		
	the resident usua	lly was understood and			be reviewed and updated ba			
		nds. He scored a 3 on his			on the resident's individual			
	1 -	of Mental Status which			needs. Care plan reviewed			
		severely impaired			quarterly and with any chang	e in		
	cognitively.				condition. #4 How will the			
	cognitively.			corrective action be monitored to ensure the deficient practice does				
	An alonament ris	sk assessment dated			not recur? Elopement care p			
	_				will be reviewed and updated			
		d he was at risk for			according to the MDS sched			
	_	ras residing on the			a minimum of quarterly. MD			
	Special Care Uni	t.			coordinator/designee will rev elopement care plans with			
					Interdisciplinary Team at leas	it		
	1	dated 5/8/11 at 22:42			quarterly. Results of the review			
		icated upon shift arrival			care plans will be forwarded			
	and rounds, nurse	e and CNA noted resident			the Quality Assurance Comm			
	_	Jnit ambulating up and			and any concerns addressed			
	down hallway. V	Visitors noted in Special						
	Care Unit visiting	g other residents.						
	Resident showed	no signs of discomfort						
	or distress. At 17	700 (5:00 p.m.) nurse						
		esident being outside in						
		Nurse noted resident						
	l -	calmly in front of						
	ı	ries or distress noted.						
	l	ow did he get out here,						
	resident stated, "	•						
	· ·	o find Broadway st.,"						
	· ·	•						
	inurse waiked res	sident back in facility						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	ILTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155580	B. WINC			05/17/2	011
		<u> </u>			DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	<u>t</u>		2350 TA	FT STREET		
	VIEW HEALTH CAR		GARY, IN46404				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEPICIENCT)		DATE
		e assessed. No injuries					
		nt denied pain. All					
	•	it windows were checked					
		were locked. Resident					
	•	nute checks. Physician					
	made aware and	no new orders.					
	A care plan initio	ated on 5/9/11 indicated a					
	-	ement risk as evidenced					
	by a history of w	•					
		s if resident was found to					
		place on 15 minute					
		urs to ensure resident's					
	safety.						
	Interview with th	ne Director of Nursing on					
	5/17/11 at 11:00	a.m., indicated the					
	resident had been	n about a block from the					
	facility. There w	vas no further information					
	· ·	rds to a specific care plan					
	for Resident #C						
	elopement.	1 <b>-8</b> m. <b>u</b> b <b>v</b> o 1115					
	cropement.						
	Federal tag relate	es to Complaint					
	IN00090300.	•					
	2 1 25(2)						
	3.1-35(a) 3.1-35(b)(1)						
F0323		nsure that the resident		1			
SS=D		ins as free of accident					
	•	sible; and each resident					
	devices to prevent	e supervision and assistance					
		review and interview the	F03	323	#1 What corrective action wil	l be	06/16/2011
	Dusca on record	10 (10 )) und mitor view the	10.		accomplished for those resid		00/10/2011

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDIN		NG 00		COMPLETED	
155580		155580	B. WING			05/17/2011		
					ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER					AFT STREET			
TIMBERVIEW HEALTH CARE CENTER				1	IN46404			
(X4) ID				ID			(X5)	
PREFIX	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL			PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE		
	facility failed to	ensure supervision was			found to have been affected by			
	· ·	f 3 residents reviewed			the deficient practice.Upon			
	_	for elopement in a			Resident #C's return to the facility he was immediately assessed			
	sample of 10 related to a resident leaving the secured unit and being found outside				with no injuries noted. Resident #C's family and physician were			
		•			notified of occurrance.#2 Hov			
	of the facility. (	Resident #C)			other residents having the			
					potential to be affected by the			
	Findings include				same deficient practice will b			
					identified and what corrective action will be taken? All resid			
		esident #C was reviewed			have the potential to be affect			
	on 5/16/11 at 10:	:46 a.m. The resident's			by the same deficient practic			
	diagnoses included, but was not limited				All facility windows were checked			
	to, altered mental status, hypertension,				by maintenance personnel a			
	dementia, and history of head trauma.				the only issue identified was			
				screw for the window in which Resident #C climbed out of. This				
	Review of the quarterly Minimum Data Set Assessment dated 4/18/11, indicated				was fixed immediately. The	11115		
					facility has now installed met	al		
		lly was understood and			bar with three screws in the t	oar to		
		nds. He scored a 3 on his		hold it in place. #3 What measures will be put into pl				
		of Mental Status which						
	indicated he was severely impaired cognitively.  An elopement risk assessment dated 4/18/11, indicated he was at risk for				what systemic changes will be made to ensure that the defice			
					practice does not recur. An	SICITE		
					inservice was held with			
					maintenance staff on preven	tative		
					maintenace programs. The			
					window inspection is on a mo	onthly		
	elopement and was residing on the			preventative maintenance program. Staff inservices to be				
	Special Care Unit.				held regarding appropriate	50		
	A progress note dated 5/8/11 at 22:42 (10:42 p.m.), indicated upon shift arrival and rounds, nurse and CNA noted resident in Special Care Unit ambulating up and down hallway. Visitors noted in Special Care Unit visiting other residents.				interventions for residents wh	no		
					trigger for elopement on or b			
					6/16/11. Activity staff schedu			
					was reviewed and ammende  How will the corrective action			
					monitored to ensure the defice			
					practice does not recur?Window			
					by			

008505

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CON		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	R: A. BUII		00	COMPLETED		
155580		1	B. WING			05/17/2011		
			P. (111)		ADDRESS, CITY, STATE, ZIP CODE	<b>I</b>		
NAME OF PROVIDER OR SUPPLIER				1	AFT STREET			
TIMBERVIEW HEALTH CARE CENTER			GARY, IN46404					
(X4) ID		SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	,	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION	
TAG	<del> </del>	LSC IDENTIFYING INFORMATION)	-	TAG	•		DATE	
	1	l no signs of discomfort			maintaince director/designee Results will be shared in qua			
	1	700 (5:00 p.m.) nurse			assurance meetings.	iiity		
	1	esident being outside in			Maintenance director/design	ee		
	front of facility. Nurse noted resident				will submit monthly preventa			
	outside walking	calmly in front of			maintenance to Administrato			
	facility's, no inju	ries or distress noted.			verification of completion and concerns	any		
	Resident asked h	now did he get out here,			addressed. Interventions to			
	resident stated, "	I climbed out my			reduce elopement risk will			
	window, I need to find Broadway st.,"				be reviewed according to the	;		
	Nurse walked resident back in facility and to room to be assessed. No injuries noted and resident denied pain. All Special Care Unit windows were checked and all windows were locked. Resident placed on 15 minute checks. Physician made aware and no new orders.				MDS schedule by the			
					Interdisciplinary team at a	.,		
					minimum of quarterly and an concerns will be forwarded to			
					QA committee for their review			
	illade aware and	no new orders.						
	The weather on	was a high of 60 degrees						
	and a low of 45 degrees with no precipitation. The back of the building has a fenced in area and some trees. The front of the facility has a packing lot and then goes to a side street with minimal traffic.  A reportable incident was provided by the							
	Administrator on 5/16/11 at 12:55 a.m.							
	The incident occurred on 5/8/11. There							
	was no injury. "Visitor/Family member							
	called into facility's stating that our							
	resident was walking outside on the sidewalk. Staff immediately ran outside and escorted resident back in the facility. When asked how he got outside he stated,							

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MU					(X3) DATE SURVEY	
AND PLAN OF CORRECTION				A. BUIL	DING	00		COMPL		
155580			B. WING				05/17/2011			
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE					
IVAIVIE OF I	ROVIDER OR SUPPLIER				2350 TA	AFT STREET				
TIMBERVIEW HEALTH CARE CENTER					GARY, IN46404					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES				ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	E			COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG		TCIENCY)		DATE		
	"I went out of a v	vindow."								
	Resident #C's na	me does reside or	ı our							
	Alzheimer's Unit									
	shows him attend		•							
		•	•							
	the day. The Star	-								
	were working as	•	Ш							
	making routine ro									
	throughout the da	ay.								
	Video shows Res	sident #C's name o	entering							
	another resident's		U							
	resident exits the									
		-	-							
	distress. Resident #C's name does not									
	leave that room.									
	Video shows Resident #C's name									
			care							
	returning with staff to the special care unit.  A detailed time line of the video surveillance, indicated Resident #C entered another resident's room at 4:49 p.m. He was noted back on the unit at 5:11 p.m.  Interview with the Administrator on 5/16/11 at 12:55 p.m., indicated the windows had a screw so that the window would only open four inches. Upon examination of all of the window in the special care unit it was found that the window in the room that Resident #C had									
entered had the screw bent. The										
FORM CMC 2			E( ID		E- 377 7	Th: 000505	TC	5	00 (04	
FORM CMS-2	567(02-99) Previous Version	ns Obsolete	Event ID:	F8PO11	Facility I	D: 008505	If continuation sh	eet Pa	ge 30 of 31	

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155580		(X2) MULTIPLE CO  A. BUILDING  B. WING	00	СОМ	(X3) DATE SURVEY COMPLETED 05/17/2011			
NAME OF PROVIDER OR SUPPLIER  TIMBERVIEW HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  2350 TAFT STREET  GARY, IN46404					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE				
	metal bar had no three screw in th She further indic thankful the fam Interview with th 5/17/11 at 11:00 resident had been facility.	rther indicated that a w been installed with e bar to hold it in place. ated she was very ily had called the facility.  The Director of Nursing on a.m., indicated the n about a block from the  The relates to Complaint						